SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No:	C02/S/b
Service	Low Secure Mental Health Services (Adults)
Commissioner Lead	*For local completion*
Provider Lead	*For local completion*

1. Scope

1.1 **Prescribed Specialised Service**

This service specification covers the provision of low secure mental health services (Adults).

1.2 **Description**

1.2.1 Secure services provide care and treatment for individuals with mental and/or neurodevelopment disorders who are liable to be detained under the Mental Health Act (MHA) 1983, and whose risk of harm to others and risk of escape from hospital cannot be managed safely within other mental health settings. Individuals will typically have complex chronic mental disorders, which are linked to offending or seriously harmful behaviour. Some individuals will be involved with the criminal justice system (CJS), courts and prison, and may have Ministry of Justice (MoJ) restrictions imposed.

1.2.2 A number of levels of security currently exist to manage increasing levels of risk to others.

Presently these consist of High, Medium and Low secure services, each of which provides a range of physical, procedural and relational security measures to ensure effective treatment and care whilst providing for the safety of the individual and others including other patients, staff and the general public.

- High secure services provide care for those who present a **grave and**

immediate danger to the public and who should not be able to escape from the hospital.

- Medium Secure services care for those who present a **serious** risk of harm to others and whose escape from hospital should be prevented.

- Low secure services care for those who provide a **significant** risk of harm to others and whose escape from hospital should be impeded.

1.2.3 Low secure services provide care for those who pose a significant risk to others and require physical security that impedes escape from hospital. Some will have been in contact with the CJS and will have either been charged with or convicted of a criminal offence. All individuals admitted to low secure services will be detained under the MHA 1983 and the decision to admit will have been based on a comprehensive risk assessment and detailed consideration of how the risks identified can be safely managed whilst in hospital.

1.2.4 This specification relates specifically to low secure mental health services provided for men and women (aged 18 and above) with mental illness (MI), personality disorder (PD) and neurodevelopmental disorders (NDD), including learning disabilities (LD).

1.2.5 NHS England currently commission approximately 7700 inpatient beds in secure mental health services.

- Approximately 800 in high secure (commissioned for England and Wales)
- Approximately 3200 in medium security and
- Approximately 3700 in low security.

1.2.6 The core objectives for secure services are to assess and treat mental disorder, reduce the risk of harm that the individual exhibits to others and to support recovery and rehabilitation. Secure services provide a comprehensive range of evidence-based care and treatment provided by practitioners, expert in the field of forensic mental health. A range of specialist treatment programmes will be available, delivered either individually or within groups. The aim is for the individual to safely return to the community, to prison or transfer out of secure services.

1.2.7 The maintenance of security is crucial to the provision of effective therapeutic interventions in secure services. A key principle underpinning the provision of secure services is that individuals should be managed in the least restrictive environment possible in order to facilitate their safe recovery. Least restrictive refers to the therapeutic use of the minimum levels of physical, procedural and relational measures necessary to provide a safe and recovery focused environment.

1.2.8 Robust procedures relating to the responsibilities of provider organisations, services and clinicians under the Mental Health Act 1983 should be put in

place and regularly reviewed.

1.2.9 Any medical treatment provided to patients must comply with Part 4 of the MHA and, where relevant, the Mental Capacity Act 2005 and the common law.

1.2.10 Low secure services will operate within an ethos that places the patient at the centre of their care and facilitates active engagement in their recovery from mental health difficulties and risk behaviours. They will promote equality of access, experience and outcomes across ethnic groups, faiths, gender, disabilities, sexual orientation and socio-economic status.

1.2.11 Due to the nature of secure services, it may be necessary for certain blanket restrictions as described in the MHA Code of Practice to apply in order to maintain the overall security of the service and to manage high levels of risk to other patients, staff and members of the public. Any blanket restriction should be a necessary and proportionate response to that risk, and be authorised and monitored through the provider organisation's operational and governance procedures respectively. The impact of a blanket restriction on each patient should be considered. Any blanket restrictions should be recorded in writing and be subject to review.

1.2.12 Secure services consist of high, medium and low secure provisions. Placement within the pathway will be determined by the level of risk of harm to others presented by the individual concerned. Progress and transition along the pathway will be determined by the reduction in assessed risk of harm to others, and a reduction in the need for care and supervision. It is expected that individuals will be treated and managed within a whole care pathway approach and services will work collaboratively with each other in order to ensure that the admission and any transfer within the secure care pathway is achieved seamlessly and efficiently. Transition between services will be kept to a minimum in order to provide effective continuity of care.

1.2.13 Low secure services provide care and treatment to a variety of individuals. The predominant need for low secure management will be related to the individual's assessed risk of harm to others in the context of mental disorder. Recognised pathways into low secure services include stepping down from medium and/or high secure care, admission direct from the criminal justice system and admission from community and adult inpatient services. An increasingly common pathway is transition from Secure Child and Adolescent Mental Health Services (Secure CAMHS).

1.2.14 There are three main patient groups in low secure services. These are patients requiring forensic low secure rehabilitation, patients requiring forensic low secure admission and extended Psychiatric Intensive Care Unit (PICU) patients.

- Patients requiring forensic low secure rehabilitation will generally have been transferred from low or medium secure services, will have been

convicted of a serious offence and be subject to a hospital order (often with restrictions) or have been transferred from prison. Included in this group will be patients who will have been transferred from general adult services, who have not generally committed a serious offence, but who present a significant risk to others and require low secure rehabilitation.

- Patients requiring forensic low secure admission will generally have been transferred from a prison setting or the courts or have been charged with an offence whilst in the community or hospital.

- Extended PICU patients are patients who require a longer period of care in a locked/secure setting, but may not meet the significant risk of harm to others criteria, which other low secure patients do. This group of patients is often better managed in locked rehabilitation services rather than low secure services.

1.2.15 The core objectives for secure services are to assess and treat mental disorder, reduce the risk of harm that the individual exhibits to others and to support recovery and rehabilitation. Secure services provide a comprehensive range of evidence based care and treatment. Low secure services are at the interface of secure services and care in the community. As such care is provided by multidisciplinary teams (MDT) which are experienced in both forensic and rehabilitation psychiatry. A range of specialist treatment programmes delivered either individually or within groups will be available. The aim is for the individual to safely return to the community or prison or transfer out of secure services and benefit from an improvement in quality of life

These objectives will be met through:

- Ensuring every patient has an agreed integrated pathway through secure care with clear therapeutic objectives agreed as early as possible.
- Effective MDT assessment of mental health and risk needs prior to admission.
- An MDT formulation of mental health difficulties and risk behaviours which establishes treatment targets and interventions required.
- Further specialist assessment of mental health and risk needs to identify the links between mental disorder and risk.
- Timely management of mental disorder and risk using specialist interventions and treatments to stabilise mental state and reduce risk of harm.
- Supporting recovery and rehabilitation through engagement and self-management.
- Ongoing engagement with all services identified in the care pathway to ensure timely discharge or transfer along the care pathway.
- Use of the Care Programme Approach (CPA) process and evidence based outcome measures to monitor progress and optimise length of in-patient stay in secure care.
- Having appropriately trained staff working in secure services.
- Having effective clinical governance and external monitoring processes of the secure care pathway.

1.3 **How the Service is Differentiated from Services Falling within the Responsibilities of Other Commissioners**

1.3.1 This service is commissioned by NHS England because:

- the number of individuals requiring the service is relatively small
- the cost of providing the service is very high because of the specialist ward environment required to provide adequate levels of both physical and procedural security and the high levels of staff necessary to provide adequate relational security;
- the number of expert staff trained to deliver the service is relatively small (in particular, they require expert knowledge of risk assessment and management as well as knowledge of the criminal justice system); and
- the cost of treating patients is very high, placing a potential financial risk on individual Clinical Commissioning Groups (CCGs.)

1.3.2 CCGs commission services for patients on the secure pathway who no longer require secure care

2. Care Pathway and Clinical Dependencies

2.1. Care Pathway

2.1.1 It is expected that each individual will be treated and managed in accordance with a care pathway. The care pathway will be planned in consultation with the individual. The care pathway, whilst not prescriptive, describes the individual's anticipated journey of transition into, through and out of secure care. The indicators and criteria used for assessing progress and transition along the pathway will include:

- Nature and degree of mental disorder and its relationship to risk.
- Level of risk to others.
- Level of care and supervision required.
- Need for input from specialist services or staff.
- Need for offence/risk behaviour related therapy.
- Level of engagement with treatment/care plan.
- Level of engagement in structured and meaningful activities.
- Level of misuse of drugs or alcohol.

2.1.2 The components of a low secure service can be described in four phases, these include:

- **Referral and assessment**

- To maintain close links with generic mental health services and to assist these services in formulating treatment programmes which

will reduce the need for admission to secure services.

- Assessment of need for admission to secure care/ transfer from another secure care environment and advice where admission is not offered.
- Providing information to the referred individual about placement, assessment process, and outcome of assessment.
- Access Assessment for low secure care is described within **Appendix 1.**

- **Pre-admission**

- Introducing the individual to key staff and other patients.
- Visits to the accepting service as appropriate
- Providing information about the accepting service, in the form of a 'Welcome Pack'
- A multidisciplinary formulation of mental health difficulties and risk behaviours which establishes treatment targets and interventions required during admission.
- Consideration of the discharge or transition pathway.

- **Admission, Care and Treatment**

- Evidence based specialist assessment, treatment and management of mental disorder
- Evidence based assessment, reduction and/or management of risk, specifically the risk of harm to others through the provision of specialist offence related treatment programmes which can be delivered either individually or within groups that address offending and risk behaviours.
- On-going appropriate risk assessment and proactive risk management strategies.
- Appropriate use of escorted and unescorted community leave.
- Assessment of fitness to plead/stand trial of in-patients and provision of advice to Courts regarding psychiatric disposal options.
- Individualised care and treatment provided in the least restrictive environment (least restrictive refers to the therapeutic use of the minimum levels of physical, procedural and relational measures necessary to provide a safe and recovery focused environment).
- Development of a care plan reflecting evidence based whole care pathway approach including transition and engagement with the next step provider.
- Recovery and outcome focused multidisciplinary treatment and intervention with the Care Programme Approach (CPA) forming the cornerstone of the delivery of an effective care pathway through secure care. CPA meetings should be held within the first three months of admission and then every six months.
- Access to social, educational and occupational opportunities that are meaningful and support rehabilitation and recovery (minimum

25 hours per week)

- Meeting physical health care needs through a full range of primary health care interventions including health promotion and physical health screening, ensuring that these are integrated into one patient record.
- Joint working protocol/care pathway with primary healthcare, specialist and emergency health teams to be developed and followed.
- Facilitating supportive engagement with family and carers, as appropriate by establishing the level of support and information needed by family and carers to enable effective engagement with them.
- Full cooperation with the First Tier Tribunal system to ensure timely review of authority for detention of patients.
- For "restricted" patients, secure services will ensure compliance with the MoJ requirements and directions.
- Providing social work services in line with national stand

- **Discharge/Transition**

- Consideration for discharge or transition should start at the point of admission and assessment.
- Effective and early liaison with forensic outreach and liaison services (FOLS), local area community services and relevant others to facilitate discharge planning reflected through an assertive care pathway management approach to ensure that transition to the community, generic mental health services or prison is carried out in a timely manner.
- Development of a care plan reflecting evidence based whole care pathway approach focusing on transition and engagement with the next step provider.
- Wherever possible continuity must be maintained to ensure that patients progress through the pathway and unnecessary delays are avoided by patients having to repeat assessments or treatments in new settings.
- For individuals supported in the community by mental health teams, development of a community care plan reflecting a whole person approach to recovery and rehabilitation into the community based on risk assessment and proactive risk management strategies.
- For individuals being discharged back to prison, effective hand over with mental health services in prison, including an end of treatment report, and an updated multi-disciplinary formulation. Services will be expected to actively liaise with Her Majesty's Prison (HMP) Service under the terms of the current remission protocols.
- Effective and early liaison with local area services and relevant others to facilitate timely transfer to local services supported post discharge by community forensic mental health teams where appropriate.
- Services should adhere to the requirement to liaise with the bodies

responsible for providing after-care services to patients under section 117 of the MHA

2.1.3 **Forensic Outreach and Liaison Service (FOLS)** This is an important and efficient component of the pathway provided from the specialist centre. These services must be provided in all geographical areas. Reference **Appendix 2**

2.1.4 **Security** Individuals in low secure care will require a combination of physical, relational, and procedural security to remain safe. The service will promote and enable recovery and independence of the individual whilst ensuring protection of the public. The application of security will be based on the risk needs of the individual, be as least restrictive as possible, and imposed only when risks have been identified. The balance between procedural, relational and environmental security will depend on the individual's need and progress along their pathway to discharge/transfer. Low secure services should impede escape; emphasis should be on good procedural and relational security. Staffing levels and skill mix should be appropriate to the requirements of the service and the patients that they provide for.

2.1.5 **Risk Management** processes will be appropriate to the care and safety of all individuals in low secure care. The risk assessment and management models shall incorporate the principles of hazard identification, risk reduction, risk evaluation and a risk management method that includes a recognised risk communication process. The service will also have a dynamic risk assessment model in place to support clinicians in making day-to-day decisions about individual care. Services should aim to support self-assessment and self- management through engaging the individual. It is important that low secure services have an ethos of positive risk taking. Care plans will reflect risk assessment and reduction over the course of the individual's detention. Governance arrangements will include analysis and shared learning of all incidents and audit of risk management processes.

2.1.6 **Recovery** Low secure services will adopt a recovery-based approach to ensure individuals in secure care drive their own outcomes and work collaboratively with staff. In keeping with the recovery approach, individuals will be encouraged to take as much responsibility as possible for their own wellbeing and progress. Low secure services will encourage individuals to be meaningfully involved in all decisions about themselves. This includes being fully involved with multidisciplinary meetings, CPA review meetings, risk assessment processes and other meetings relating to their care and treatment. All information about the service, treatment and care plans will be in a format that individuals can access and understand taking into account individual communication needs.

2.1.7 **Involvement** Secure services will have in place an involvement strategy

and system to support individuals to be involved in their care, treatment and pathway plans, and decision making at all levels of the organisation. This includes representation in governance structures, policy-making and service development.

2.1.8 **Carers** Low secure services will have in place a carer engagement and involvement strategy and a system and protocols to support carers to be involved in the care, treatment and recovery pathway plans. This will be subject to agreement with the individual concerned. The strategy will define how the needs of carers will be addressed and supported by the service.

2.1.9 **Advocacy** An Independent Mental Health Advocacy (IMHA) service will be commissioned by the provider to ensure individual rights are safeguarded. Advocacy services will work towards the self-advocacy model and will support individuals as necessary and specifically in relation to CPA meetings and transition planning.

2.1.10 **Leave** Well-planned task-orientated leave of absence has an important part to play in rehabilitation and recovery by providing a means for assessment of risk and progress; the development of social, interpersonal and practical skills; providing access to resources' promoting physical and mental wellbeing, and supporting community reintegration. Granting of leave, escorted or unescorted, will follow effective risk assessment which must include assessment of risk of absconding and risk of harm to the public while the patient is on leave or should they abscond, and respect the feelings and fears of those who may have been affected by the patient's past actions. Where relevant, leave will be planned taking into account victim support services and Multi Agency Public Protection Arrangements (MAPPA). The care plan will indicate the expected provision of staff resources and non-staff resources required to safely and appropriately minimise any risks during leave and set out clearly a Contingency Management Plan in case of untoward events. Services must comply with the relevant legislation when authorising and granting leave.

The care plan should also include how the planned leave will help with the service user's recovery journey. When leave is escorted, the individual will remain in the care of staff who have the necessary training and competence to convey and restrain the individual if required. Physical and/or mechanical restraints may be required for the protection of the public and staff in accordance with the guidance provided in the MHA Code of Practice.

Overnight leave may become appropriate close to transition from the low secure service. Trial leave from low secure care will not usually be necessary as the step down and transition services will be engaged early in the individual's pathway unless there are clear clinical or risk reasons for this.

2.1.11 Observations. Special or enhanced observations should only be considered within a framework of support and engagement with patients and staff to minimise risks and prevent the need for prolonged special or enhanced observation. This will be assured through a policy on observation and engagement, and the maintenance of environmental, procedural and relational safety to uphold dignity, respect and care for the individual and reflect their immediate needs and the needs of others. The need for enhanced or special observations will be regularly reviewed and be reduced to the minimum level necessary at the earliest opportunity while maintaining safety.

2.1.12. **Acceptance Criteria**

- Presence of a mental disorder which is of a nature and/or degree warranting detention in hospital for medical treatment and appropriate treatment is available.
- Detained under the MHA 1983.
- Individuals will predominantly present a significant risk of harm to others and to manage this risk requires low secure in-patient care, specialist risk management procedures and specialist treatment interventions.
- Those suitable for transfer from prisons will generally be charged with, or have been convicted of, a specified violent or sexual offence as defined in Schedule 15 of the Criminal Justice Act 2003 or another serious offence, such as arson.
- Individuals may be accepted without criminal charges pending, where there is clear evidence of a significant risk to others in the context of mental disorder. There will generally be a pattern of assaults and escalating threats.
- Potential to benefit from the treatment/assessment provided or to prevent deterioration.
- The individual is not safely managed in a non-secure environment.
- Individuals may present a risk of escape.
- Individuals with a mental disorder directed to conditions of low security by the (MoJ).

2.1.13**. Exclusion criteria:**

- Individuals who present a 'grave and immediate risk' or 'serious risk' to the general public, i.e. those individuals who should be managed in high or medium security.
- Low security is not required for those who present with disturbed or challenging behaviour during episodes of mental disorder that are likely to be relatively brief. Such individuals are more properly cared for in local generic mental health provision including PICUs.
- Individuals will not normally be admitted to low security if the predominant risk is of self-harm and who do not present a significant risk of harm to others. An exception to this might be for individuals serving long prison sentences for non-violent or non-sexual offences who, because of the risk of escape or as a result of MoJ direction,

cannot be transferred to a non-secure environment.

2.2 Interdependence with other Services

Low secure services are part of a spectrum of services whose function is to best meet the needs of those with mental disorder and/or neurodevelopmental disorder who will benefit from specialist care and treatment within a secure environment. In support of the care pathway secure services will provide advice to referrers or other interested parties on the management of individuals as appropriate. Secure services support patients in their recovery and rehabilitation so they can move to a less restrictive environment as soon as possible. Secure services will establish close working relationships with other services which form part of the individual's care pathway.

2.2.1 Key partnerships include:

- NHS England
- High secure and medium secure services
- Appropriate NHS / Independent / Third Sector providers
- Local mental health services (including PICUs and community mental health services)
- Advocacy Services, including Independent Advocacy as appropriate
- Carer Support Services
- Department of Health (DoH)
- Ministry of Justice (MoJ)
- Courts
- Police
- National Offender Management Service (NOMS)
- Multi Agency Public Protection Arrangements (MAPPA)
- National Probation Service
- The Prison Service including public sector and private prisons
- Health and Justice commissioned offender health services
- Offender Personality Disorder pathway commissioned services
- Social Care Agencies
- Care Quality Commission (CQC)
- Appropriate Regulators
- Housing associations and other providers of accommodation

2.2.2 The service is expected to have protocols in place to enable it to share clinical information with other agencies when appropriate which are underpinned by Caldicott principles and information governance structures.

2.2.3 Appropriate accommodation will be made available by the provider for the provision of advocacy services. This will be underpinned by a robust protocol of engagement agreed between NHS England, the low secure service and the advocacy provider.

2.2.4 Low secure services will provide training and education programmes and will participate in research/development activity which promotes the continual improvement of the service and outcomes for service users. In addition they will ensure that their service users have equal access with non-secure service users to participate in research activity. The service will ensure that staff are able to participate in these activities without affecting care and treatment or business continuity.

2.2.5 There will be a well-managed interface with child and adolescent mental health services (CAMHS), in particular CAMHS forensic in-patient services, to ensure smooth transition in provision for high-risk young people to adult services.

3. Population Covered and Population Needs

3.1 **Population Covered By This Specification** The service outlined in this specification is for individuals who are the commissioning responsibility of the NHS England

3.2 **Population Needs**

3.2.1 Low secure services are for adults with mental disorder who require care and treatment in a low security because of the significant risks they present to others. There may be times when some individuals require a more specialist service. The information below describes the specifics in relation to these services.

3.2.2 **Individuals who are culturally deaf (D) and audiologically deaf (deaf)**

Secure services shall ensure that for D/deaf individuals the necessary communication/ hearing aids are organised for the assessment process. At the initial assessment a brief communication assessment will be undertaken by specialised deaf services staff and following admission, a more formal communication assessment will be undertaken by the Speech and Language Therapist and Deaf Support Worker (preferably including video recording of the individual) unless already available. This will include a detailed audiometry assessment. In some cases admission to a low secure deaf service will be required.

3.2.3 **Individuals with Neurodevelopmental Disorders (NDD)**

NDD are mental disorders, beginning before adulthood, which lead to impaired social and psychological functioning. The term encompasses learning disabilities, pervasive developmental disorders within the autism spectrum, acquired brain injuries in childhood, and other developmental communication disorders. Neurodevelopmental disorders are common: approximately 2 % of the adult population in the UK has a learning disability

and 1 % is on the autism spectrum.

NDD present as a spectrum, with mild to severe impact on functioning. All low secure units will be able to support individuals who are at the mild end of the spectrum in the treatment of their mental illness and/or personality disorder, with only minor adjustments to the care provided, and making use of advice and expertise from more specialist units as and when required.

In order to ensure reasonable adjustments can be made, all low secure services will provide screening for NDDs, a clear pathway for formal diagnosis delivered in partnership with specialist NDD services, and access to independent advocacy and external support networks with experience in the management of people with NDD.

When such adjustments are not sufficient to allow participation in treatment, or when the view of the specialist NDD service is that treatment is needed for the impact of NDD itself, then treatment may be within a specialist NDD service.

Care pathways for individuals with NDD might include periods in a low secure service for people with NDDs, and periods in a more mainstream secure service. This is likely to be a particular consideration at points of transfer between levels of security, or out of hospital into community provision. Where people with NDDs are treated in mainstream secure services, staff should have sufficient skills to meet their communication and treatment needs.

Care and Treatment Reviews (CTR) have been developed as part of NHS England's commitment to transforming the services for people with learning disabilities and/ or autism who display behaviour that challenges. All low secure services will support commissioners to host CTRs for individuals with a LD and/or Autism. This will be in addition to the CPA process.

Services will ensure that people with LD and autism have access to physical healthcare services with professionals able to meet the needs of people with neurodevelopmental disorders, taking account of the recommendations of the Confidential Enquiry Into the Premature Deaths of People With LD. These services will be expected to participate in national programmes to monitor unexpected adverse health outcomes for their service users.

Services may provide a specialist outreach function to support community integration of people with NDD who have previously been in the inpatient service.

Individuals with Learning Disability (LD)

Although LD may be considered a mental disorder in its own right, typically people with a LD who require low secure care will do so due to the presence of another mental disorder, and in particular PD and/or mental illness. The primary reason for treatment in low secure care is likely be to treat those

comorbid disorders which are amenable to treatment, and where treatment of those disorders is likely to reduce the risk of harm to others.

Placement of people with LD is not defined on the basis of global IQ score but on the basis of treatment need. People with very mild or borderline intellectual impairment and/or social functioning may be appropriately placed in a mainstream low secure service. Those with significant intellectual disability or whose presentations are significantly complicated due to the presence of LD may require adapted environments or treatment programmes, and will be better placed in specialist low secure LD services.

Individuals with more severe intellectual impairment, who are unable to access even highly adapted treatment programmes, or whose risk to others relates primarily to challenging behaviour, will not be appropriately placed in a low secure service.
The environment in a specialist LD low secure service will be designed to include appropriate space, adapted signage, decoration, lighting, and access to sensory areas. Service users will have access to adapted information, taking account of the sensory and communication needs of individuals.

Specialist LD low secure services will have a clinical team with skills and competence in working with people with LD, including access to appropriately trained psychiatrists, psychologists, occupational therapists, speech and language therapists, dysphagia specialists, sensory integration trained therapists, and an appropriate mixture of registered learning disability and mental health nurses. There will generally be a higher staff to patient ratio compared to mainstream low secure services.

Clinical and service pathways will take into account the individual's LD in providing treatment for any offending behaviour and will allow maximum participation of the individual in their own care pathway.

An adapted care pathway will be provided, including specialist-led access assessment, routine sensory integration, communication, intellectual and adaptive function assessments, and routine diagnostic assessment for co-morbid conditions including mental illness, personality disorder and autism. Positive Behavioural Support (PBS) will be used to understand functional behaviour and arousal cycles to minimise their impact.

Adapted treatment programmes, including group and individual psychological therapies, will be available to address the underlying disorder(s) that contribute to offending and aid rehabilitation. In addition, programmes will be available which support the development of life skills to allow service users to live as independently as possible in the community.

There will be access to teaching professionals providing specialist education within the service. The staff team will be involved in the formulation of need, and training of receiving units/teams and/or community placements.

Individuals with Autism

Typically, a specialist low secure autism service will be suitable for the following:

- those whose autism has a significant impact on the expression of co-morbid mental disorders and social functioning, which is related to a pattern of harmful behaviour, requiring treatment;
- those where specific adaptations are required to treatment programmes in order to take account of the cognitive processing abilities of the individual with autism;
- those where there is a need for specialist assessment of autism, in a person where there is significant risk of harm to others, and where that assessment requires the daily observation and intervention of a specialist team.

The need for specialist low secure autism services is independent of global intellectual ability, though for those with greater global impairment their needs may be as well served in a specialist LD service.

Specialist low secure autism services will have a purposefully-designed environment to meet the needs of people with autism. There will be less than 10 patients per ward area. Units will be spacious with clearly demarcated areas and rooms. Lighting, acoustics and ward decorations will be managed in a way that is sympathetic to the sensory needs of this client group.

There will be a high ratio of staff to patients, with specific attention to the need for high relational security to support the delivery of a continuous treatment programme that includes providing social scaffolding and modelling of relationships. Staff will have experience in working with people with autism, including working with their families. Staff will receive ongoing training on autism spectrum disorder, and the team will include staff, of all disciplines, trained in the use of diagnostic tools for autism. Positive Behavioural Support (PBS) will be used to understand functional behaviour and arousal cycles to minimise their impact. Treatment programmes to address risk and offending behaviours will be adapted to meet the needs of people with autism.

Integrated into the Multi –Disciplinary Team (MDT) will be the significant provision of speech and language therapy and occupational therapy, to provide the right communications, structure and predictability to support the development of positive relationships and social learning. There will be access to sensory integration trained therapists.

Clinical and service pathways are likely to be highly individual. Minimising the number of transitions is important, The staff team will be involved in the formulation of need and training of receiving units/teams and/or community placements. The staff team will provide outreach to other secure units, including LD and Mental Health Units

3.2.4 **Individuals with a diagnosis of Personality Disorder (PD)**

- All low secure services staff, including patient facing non-clinical staff, will have specific training and competence in working with PD patients, in particular the need to work interpersonally and to manage patients who consistently push boundaries.
- Staff selection procedures should take into account the ability to work with such challenging behaviour
- Services should be psychologically informed, including the ward milieu which should focus on opportunities for relating, and maintaining optimistic boundaries and collaborative relationships between staff and patients. Sufficient attention must be paid to the environment around the individual as well as the interactions between people, to offer structure support, validation, and opportunities to practice new ways of relating.
- All staff, including patient facing non-clinical staff should receive support supervision and reflective practice opportunities, led by a clinician with expert knowledge in working with PD
- A holistic psychological formulation should drive the recovery plan. Attention is paid to biological, psychological, social and risk needs; these are seen as part of the whole person and not split off and dealt with separately
- A range of evidenced psychological treatments should be offered as described in NICE guidance; it should be recognized that there is no evidence that any one treatment modality over another offers advantages, but rather it is the eclectic use of tools within the supportive and hopeful relationship between patient and clinician which drives change.
- There should be continuity and consistency of relationships with staff over time and in particular with key workers, and during transitions from and to other services.

3.2.5 **Women's Services**.

There are essential differences in the profiles of women who access low secure mental health services compared to men. Women may be are more likely to have a borderline personality disorder either as a primary or secondary diagnosis, have a complex trauma history and disordered attachments. They have different offending patterns and often present with complex behaviours, including serious self-injury or attempted suicide. They also have distinct social and physical health needs.

Women's low secure services should provide gender sensitive / specific care reflecting the different needs of women who access these services. In practice this should include;

- There should be an emphasis on dignity, empowerment and relational security so that women feel safe and secure to enable them to engage in treatment.
- Whether the service is stand-alone or part of larger low secure service, wards will be single sex and women should have access to female only therapeutic / activity / outdoor space. There should be dedicated facilities (and procedures) for child visiting.
- There is a gender staffing team in region of 70:30 % (female to male), female staff are available at all times on the ward and the multidisciplinary team is mixed gender. The pre-admission assessment team should include at least one female member of staff and there should be a choice of female keyworker.
- There are polices for the individualised management of self-harm and violence which take into consideration a woman's trauma history.
- There is a program of training for staff on gender sensitive / specific care, clinical supervision and post incident support/debriefs.
- The acceptance and exclusion criteria for women's low services are no different to that defined already. Access assessments, as described in appendix 1, should take into consideration the range of services within the women's offender personality disorder pathway where the criteria apply.
- Assessments and treatment plans are individualised and cover the key elements including self-harm, gender specific formulation of risk, cultural needs, physical health, medication, eating disorders, trauma, substance misuse and family and carers.
- There are evidence based psychological treatments available for women including for psychosis, trauma, substance misuse and for personality disorder (including emotionally unstable personality disorder).
- There are offending behaviour programs which include those offences more common in women's secure service e.g. arson.
- There is the availability of a female General Practitioner, access to screening programs, secondary healthcare and there is a program of health promotion.
- The service has links with women's community resources and is part of a clinical pathway for women with links to community mental health services, appropriate step down facilities and supported housing.

4. Outcomes and Applicable Quality Standards

4.1 Quality Statement – Aim of Service

Low secure services aim to provide therapeutic services for individuals with a mental disorder - mental illness, personality disorder, and neurodevelopmental disorder - who are assessed as presenting a serious

risk of harm to others. All low secure services will be recovery-orientated and outcome-focused. The fundamental strategic aim for all secure services is to deliver a model of integrated services incorporating all elements of the pathway.

NHS Outcomes Framework Domains

Domain 1	**Preventing people from dying prematurely**	✓
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	✓
Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓

4.2 **Indicators Include:**

No.	Indicator	Data source	Domain(s)	CQC Key Question
Clinical Outcomes /Quantitative Data where possible using national data need to minimise the burden				
101	Risk Reduction - Average length of time to first escorted community leave	TBC	2, 3	Safe, effective
102	Risk Reduction - Average length of time to first unescorted community leave	TBC	2, 3	Safe, effective
103	Risk Reduction - Average length of Stay measured in occupied bed days	Contract schedule	1, 2, 3, 5	Safe, effective, caring

104	Risk Reduction - Number of patients readmitted to secure care	TBC	1, 3, 5	Safe, effective, caring
105	Recovery - % urgent referrals for access assessment ordinarily undertaken within 24 hours. in accordance with timescales set out in commissioning guidance for access assessment	TBC	3, 5	Safe, effective, caring, responsive
106	Recovery - % routine referrals receiving a multi-disciplinary access assessment within 20 working days of all necessary information being available to referrer	TBC	3, 5	Safe, effective, caring, responsive
107	Recovery - % patients with co-produced outcome-focussed CPA progress plan (covering as a minimum improved mental health, reducing problem behaviour, developing insight, minimising substance misuse, making feasible plans, improved physical health, better life skills and healthy relationships)	Contract schedule	2, 3, 4, 5	Safe, effective, caring
108	Recovery - % patients with clear discharge planning evidenced in CPA plan	Contract schedule	3, 4	Safe, effective, caring
109	Recovery - % patients with identified community care coordinator	TBC	3, 4, 5	Safe, effective, caring
110	Recovery - % patients with recovery focussed meaningful activity for 25 hours per week	Contract schedule	2, 3, 4, 5	Safe, effective, caring
111	Recovery - % patients discharged from hospital to	TBC	3, 5	Safe, effective,

		a community forensic/outreach team			caring
	112	Recovery - % patients with a multi-disciplinary formulation of risk and needs	TBC	1, 2, 3, 4	Safe, effective, caring
	113	MH Improvement - % patients with improved HoNOS score	Contract schedule	2, 3, 4, 5	Safe, effective, caring
	114	MH Improvement - % patients who understand their condition and how to manage it	TBC	3, 4	Safe, effective, caring
	115	MH Improvement - % patients with dual diagnosis whose care plans address substance misuse	TBC	1, 2	Safe, effective, caring, responsive
	116	Physical Health Improvement - % patients registered with a GP and with access to a primary care service	Contract schedule	3, 4	Effective, caring
	117	Physical Health Improvement - % patients registered with dentist	Contract schedule	3, 4	Effective, caring
	118	Physical Health Improvement -% patients receiving annual physical health check	TBC	1, 2, 3, 4	Safe, effective, caring
	119	Physical Health Improvement - % patients with physical healthcare improvement plan	TBC	1, 2, 3, 4	Safe, effective, caring
	Patient Experience				
	201	% of patients offered participation in organising their own care	TBC	2, 3, 4	Caring
	202	Secure patient experience/outcome measure (including happiness and hope)	Contract schedule	2, 3, 4	Caring
	203	% patients who believe they	TBC	2, 3, 4	Effective,

	are listened to and can change things in the service			caring
204	% patients with a completed PROM	Contract schedule	2, 3, 4	Effective, caring
Structure and Process				
301	Multi-disciplinary team	Self-declaration	3, 4, 5	Well-led, effective
302	CPA frequency	Self-declaration	2, 3, 4, 5	Safe, effective, caring, responsive
303	There are agreed clinical protocols/guidelines.	Self-declaration	1, 3, 5	Safe, effective, caring
304	Risk Reduction - Continued improvement trajectory across adverse reporting data, as specified in contract schedule	Self-declaration	1, 2, 3, 4	Well-led, safe, effective, caring

Detailed definitions of indicators, setting out how they will be measured, are included in schedule 6.

4.3 Commissioned providers are required to participate in annual quality assurance and collect and submit data to support the assessment of compliance with the service specification as set out in Schedule 4A-C

4.4 Applicable CQUIN goals are set out in Schedule 4D

5. Applicable Service Standards

5.1 **Applicable Obligatory National Standards**

The evidence for best practice exists within a range of nationally agreed standards, guidance frameworks and legislation, as well as mental health literature associated with mental disorder.

Services shall deliver in accordance with:

- See Think Act (DH 2010) – http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/forensicmentalhealth/seethinkact.aspx

- Royal College of Psychiatrists Quality Network Standards for Forensic Care CCQI www.qnfmhs.co.uk

- Mental Health Act 1983 and Code of Practice 2015
  https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983
  http://www.legislation.gov.uk/ukpga/2007/12/contents

- Mental Capacity Act 2005 and Code of Practice 2007 and supplement to the Code on the Deprivation of Liberty Safeguards 2007
  https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice
  http://www.legislation.gov.uk/ukpga/2005/9/contents

- Criminal Justice Act 2003
  http://www.legislation.gov.uk/ukpga/2003/44/contents

- The Five Year Forward View for Mental Health - A report - NHS England

- Implementing the Mental Health Forward View for Mental Health (February 2016)

- Building the Right Support: A national implementation plan to develop community services and close inpatient facilities and Care and Treatment Reviews: Policy and Guidance (October 2015)
  https://www.england.nhs.uk/learningdisabilities/natplan/

- The Good Practice Guide. The Transfer and Remission of Adult Prisoners under s47 and s48 of the Mental Health Act

- Services will ensure compliance against the Care Quality Commission's (CQC) "Essential Standards of Quality and Safety" (2010) http://www.cqc.org.uk with respect to maintaining safety and in the management of emergencies. This includes appropriate staff competence and staffing levels, suitable on call arrangements, access to emergency medical equipment and rapid access of emergency services into the unit. All staff involved in administering or prescribing rapid tranquilisation, or monitoring individuals to whom parenteral rapid tranquilisation has been administered, will receive on-going competency training to a minimum of Intermediate Life Support (ILS – Resuscitation Council UK) covering airway, cardio-pulmonary resuscitation [CPR] and use of defibrillators. The policy for Rapid Tranquilisation will be easily accessible to all staff

- NICE Guidance for the treatment of the following in particular and any other as applicable must be adhered to :

CG136	Service User Experience in Adult MH
CG82	Schizophrenia

CG38	Bipolar disorder
CG90	Depression in adults
CG120	Psychosis with coexisting substance
CG77	Antisocial personality disorder
CG78	Borderline personality disorder
CG51	Drug misuse: psychosocial interventions
CG25	Violence (short-term management)
CG133	Self-harm (longer term management)
CG142	Autism in adults

5.2 Other Applicable National Standards to be met by Commissioned Providers

5.3 Other Applicable Local Standards

Not Applicable

6. Designated Providers (if applicable)

Not applicable

7. Abbreviation and Acronyms Explained

The following abbreviations and acronyms have been used in this document:

- MI – Mental Illness
- NDD – Neurodevelopmental Disorder
- LD – Learning Disability
- PD – Personality Disorder
- PBS – Positive Behavioural Support
- MDT – Multidisciplinary Team
- CPA – Care Programme Approach
- CTR – Care and Treatment Review
- FOLS – Forensic Outreach and Liaison Service
- PICU – Psychiatric Intensive Care Unit
- DoH – Department of Health
- MAPPA – Multi Agency Public Protection Arrangements
- CAMHS – Child and Adolescent Mental Health Services
- CCGs – Clinical Commissioning Groups
- MHA – Mental Health Act
- IMHA – Independent Mental Health Advocacy
- CJS – Criminal Justice System
- HMP – Her Majesty's Prison
- NOMS – National Offender Management Service
- CQC – Care Quality Commission

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